<i>;</i>	1. TRANSMITTAL NUMBER: 2. STATE:				
TRANSMITTAL AND NOTICE OF APPROVAL OF	2003 Florida				
STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)				
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE				
DEPARTMENT OF HEALTH AND HUMAN SERVICES	July 1, 2003				
5. TYPE OF PLAN MATERIAL (Check One):					
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CON	SIDERED AS NEW PLAN				
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEN	DMENT (Separate Transmittal for each amendment)				
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:				
42 CFR 440.225, 42 CFR 440.120(d)	a. FFY				
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SE	ECTION			
Attachment 3.1-A, Pages 4.5, 34 and 35	OR ATTACHMENT (If Applicable): Attachment 3.1-A, Pages 4, 5, 34, 3.	5 36			
Attachment 3.1-B, Pages 4, 5, 32 and 34	Attachment 3.1-B, Pages 4, 5, 32, 3	3, 34			
Attachment 4.18-A, Page 1 Attachment 4.18-C, Page 1	Attachment 4.13-A, Page 1				
Attachment 4.19-B, Pages 26 and 27	Attachment 4.18-C, Page 1				
	Attachment 4.19-B, Pages 25, 27				
11. GOVERNOR'S REVIEW (Check One):  GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  12. SIGNATURE OF STATE AGENCY OFFICIAL:	OTHER, AS SPECIFIED:  Comments vall be forwarded when rec	eived			
12. SIGNATURE OF STATE AGENCY OF TICKE.	16. RETURN TO:				
13. TYPED NAME:	Mr. Bob Sharpe				
Mr. Bob Shavra	Deputy Secretary for Medicaid Agency for Health Care Administration				
14. T#LE:	2727 Mahan Drive, Mail Stop #8				
Denuty Socretary for Medicaid	Tallahassee, Florida 32308				
15. DATE SUBMITTED: 9/8/03	ATPINA VON NORTH				
	ATIN: Kay Newman				
17 DATE RECEIVED:	18. DATE APPROVED:				
	20. SIGNATURE OF REGIONAL OFFICIAL:				
Inly 1 2003	R. J. Mary C. Star Cores	100			
	22. THE Acting Associate Regional Admin				
Susan Cuerdon	Division of Sedicald & Children's Real	HI I			
23, REMARKS:					

Revision: HCFA-PM-85-3 (BERC)

**HAY 1985** 

ATTACHMENT 3.1-A

Page 4

OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY WEEDY

9.	Clinic services.	
	/X/ Provided: // We limitations X/ With limits	tions*
	// Wot provided. (7-1-85)	
10.	Dental services.	
•	/X/ Provided: // We limitations X/ With limits	tions*
•	/ / Not provided.	
11.	Physical therapy and related services.	
٤.	Physical therapy.	
	/X/ Provided: // Wo limitations /X/ With limita	tions*
	/ Not provided.	
ъ.	Occupational therapy.	
	$\frac{1}{1}$ Provided: $\frac{1}{1}$ Wo limitations $\frac{1}{1}$ With limitations	ions*
	/ / Wot provided.	. ,
c.	Services for individuals with speech, hearing, and language (provided by or under the supervision of a speech pathologis audiologist).	disorders t or
	Provided: // Wo limitations // With limitat	ions*
	Y Wot provided.	

\*Description provided on attachment.

TW Wo. 03-20
Supersedes Approv
TW Wo. 90-60

Approval Date NOV 10, 2003, Effective Date 7/1/03

Revision: HCFA-PM-85-3 (BERC)

MAY 1985

ATTACHMENT 3.1-A

Page 5

OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12.	presc	ribed drugs ribed by a etrist.	, den physi	tures, a	and prosth	etic devi iseases o	ces; and eyeglasses f the eye or by an	
٠.	Presc	ribed drugs	١.					
	/ <u>x</u> /	Provided:		No lim	itations	/X/	With limitations*	
		Not provid	led.				(6-1-75)	
ъ.	Dentu	res.		•				
	<u>/x/</u>	Provided:		No lim	itations	<u>x</u> /	With limitations*	
		Not provid	led.				(7-1-80)	
c.	Prost	hetic devic	es.					
	<u>/x/</u>	Provided:		No lim	itations	/X/	With limitations*	
		Not provid	led.				(7-1-80)	
đ.	Eyegl	asses.						
		Provided:		Wo lim	itations		With limitations*	
	<u>/X/</u>	Not provid	led.					
13.		diagnostic other than					habilitative services, e plan.	
8.	Diagn	nostic servi	ices.				*	
	/X/	Provided:		No lim	itations	<u>/X</u> /	With limitations*	
		Not provid	ied.					
*Desc	riptio	on provided	on at	tachmen	<b>.</b> .		•	
Super	. <u>03-</u> sedes	_	App	roval D	te Nov	<u>10, 2</u> 003	Effective Date 7/1/03	<u> </u>
	•						HCFA TD: 0069P/000	)2P

### 10/1/97 <u>Eyeglasses/Contact Lenses</u> (12d)

For non-EPSDT recipients twenty-one years of age and older, contact lenses will be provided for limited conditions, and require prior authorization. Eyeglasses are not covered. Prosthetic eyes and services related to measuring, fitting and dispensing are reimbursed. Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 2003-20 Effective 7/1/03 Supersedes 97-18 10/1/90 <u>HEARING SERVICES</u>: For non-EPSDT recipients 21 years of age and older, services are not covered. Refer to the EPSDT section for EPSDT limitations.

Amendment 2003-20 Effective 7/1/03 Supersedes 93-02 Approval <u>NoV 10</u>, 2003

ATTACHMENT 1.1-8 Fage 4 OND No. 0918-0193

	FLORIDA
tate/Territory:	

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED HEDICALLY MENDY GROUP(S):  ALL							
8.	Priv	rate duty nu	rsing	services.			
	<u>/X/</u>	Provided:	口	We limitations	<u>α,</u>	With limitation	ns#
9.	Clin	ic services	•				
	1/2/	Provided:	二	We limitations	180	With limitatio	ne*
10.	Dent	al services	•				
	12/	Provided:	7	Wo limitations	14	With limitatio	ns#
11.	Phys	ical therap	y and :	related services.	•		
<b>a.</b>	Phys	ical therap	7.				•
	W	Provided:		To limitations	<u>/x/</u>	With limitation	ns <sup>±</sup>
<b>b</b> .	Occu	pational th	erspy.			-1	
	131	Provided:	7	We limitations	<u> </u>	With limitatio	ns#
c.	Serv Prov	vices for invided by or	dividu: under :	sis with speech, supervision of a	hearing speech	, and language pathologist or	disorders audiologis
		Provided:	乊	To limitations	7	With limitatio	ns#
12.	Pres	Not provide drug deribed by a metrist.	e. deni	tures, and prosth cian skilled in d	etic de Liseaser	vices; and eyes of the eye or	lasses by an
<b>a.</b>	Pros	eribed drug	<b>s</b> .				
	<b>₹</b>	Provided:	7	We limitations	<u> </u>	With limitation	ns*
b.	Dent	ures.					•
	1XI	Provided:	7	We limitations	1:0	with limitatio	ns#
*Descr	iptio	n provided	on att	schment.			

TH No. 03-20. Supersedes

Approval Date NOV 10, 2003 Effective Date 7/1/03

TH No. 90-60

HCFA ID: 0140076 ---

HCFA - Region VI November 1990

ATTACHMENT 3.1-B Page 5

	:	State/Territ	ory:	FLORIDA		
		AMOUNT HEDICALL	. Dura:	TION AND SCOPE OF CEOUP(S): ALL	SERVI	CES PROVIDED
c.	Pros	thetic device				
	<u>√X</u> /	Provided:		We limitations	νX	With limitations*
đ.	Eyes	lasses.	/X/ No	ot provided		
		Provided:	乊	No limitations	口	With limitations*
13.	Othe	r diagnosti , other than	c, scr n thos	eening, preventive provided elsewh	e, and ere in	rehabilitative services, this plan.
8.	_	nostle serv				
	<u>/X/</u>	Provided:		No limitations	X	With limitations*
ъ.	Scre	ening servi	ces.			
	<u>/X/</u>	Provided:	二	Wo limitations	<u>X</u> /	With limitations*
c.	Prev	ventive serv	ices.	NOT PROVIDED		
	二	Provided:	二	So limitations	乙	With limitations*
đ.	Reha	bilitative	servic	••.		
	<u>√X</u> 7	Provided:	_	No limitations	<u>/X/</u>	With limitations*
14.,	Seri	vices for in	dividu	als age 65 or old	ier in	institutions for mental
<b>a.</b>				rvices. NOT P		
	口	Provided:	二	No limitations	一口	With limitations* .
ъ.				lity services. 1		
*Desc	_/ ripti	Provided: on provided	on at	No limitations tachment.	口	With limitations*
TH Ho Super			Appr	oval Date Nov j	0,200	3 Effective Date 7/1/03

10/1/90 <u>HEARING SERVICES</u>: For non-EPSDT recipients 21 years of age and older, services are not covered. Refer to the EPSDT section for EPSDT limitations.

Amendment 2003-20 Effective 7/1/03 Supersedes 93-02 Approval Nov 10, 2003

## 10/1/97 <u>Eyeglasses/Contact Lenses</u> (12d)

For non-EPSDT recipients twenty-one years of age and older, contact lenses will be provided for limited conditions, and require prior authorization. Eyeglasses are not covered. Prosthetic eyes and services related to measuring, fitting and dispensing are reimbursed. Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 2003-20 Effective 7/1/03 Supersedes 97-18

Approval Nov 10, 2003

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT State <u>FLORIDA</u>

a. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type	of Charge oins. Copay	Amount and Basis for Determinations		
	Deduct. C	oins. Copay			
		[			

TN No. <u>03-20</u>

Approval Date NOV 10, 2003

Effective 7/1/03

Supersedes TN No. \_02-11

Attachment 4.18-C Page 1

OMB NO.: 0938-0193

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT State FLORIDA

A. The following charges are imposed on the medically needy for services:

Service	Type	of Char	rge	Amount and Basis for Determinations		
	Deduct. (	Coins.	Copay			
		ĺ				

TN No. <u>03-20</u>

Approval Date Nov 10, 2003

Supersedes TN No. 94-11

### METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/90 EYEGLASSES/CONTACT LENSES – Reimbursement for contact lenses is based on a fee schedule established by the state agency.

Amendment 2003-20 Effective 7/1/03 Supersedes 93-02 Approval\_Nov'\_10; 2003

#### METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/90 <u>HEARING AIDS</u> – No longer provided.

Amendment 2003-20
Effective 7/1/03
Supersedes 93-02
Approval  $\Delta DV D_1 \Delta DD 3$